CITY OF SANTA CLARA
REQUEST FOR FAMILY AND MEDICAL LEAVE

Employee Name _____ Employee Number_____

Department/Division _____ Hire Date _____

Print Supervisor's Name _____

Family and Medical Leave is requested for the following reason (Check one):

- ❑ The birth of a child and/or care for that child
- ❑ The placement of a child for adoption or foster care
- ❑ The care for an immediate family member because such family member has a serious health condition (Must submit "Physician Certification" within 15 days.) Check one:
  - ❍ Child ❍ Spouse ❍ Parent
- ❑ Employee's own serious health condition that makes the employee unable to perform the functions of his/her position (Must submit "Physician Certification" within 15 days.)

The requested dates for Family and Medical Leave are _____ through _____.
The type of leave that is requested is:

- ❑ Consecutive Leave
- ❑ Intermittent or reduced leave schedule (please specify) _____
  _____

During my Family and Medical Leave, please use my following leave accruals, as available:

- ❑ Sick leave (City Manager approval is required for Family Sick leave usage over the maximum allowed by MOU).
- ❑ Vacation
- ❑ Compensatory Time Off (comp time, CTO)
- ❑ Do not use my leave accruals while I am on leave. I understand with this option, I will not accrue vacation, sick leave, or holidays while on a no-pay status.

During my Family and Medical Leave, I elect to:

- ❑ continue health coverage ❑ drop health coverage
- ❑ continue dental coverage ❑ drop dental coverage
- ❑ continue basic life insurance ❑ drop basic life insurance

If the duration of my Family and Medical Leave (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same or equivalent position. I understand that if my Family and Medical Leave should exceed 12 weeks, I will be returned to my same or equivalent position **only if available**. If my same or equivalent position is not available, I understand I may be terminated.

Signature _____ **Date** _____

Supervisor's Acknowledgment _____ **Date**_____

Human Resources Approval _____ **Date**_____

Human Resources Use Only:
Current Leave Accrual Balances: Sick _____ Vacation _____ CTO_____
Number of prior Family and Medical Leave hours taken in 12-month cycle: _____(hours)